

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day / 70th
1-19-19 / 2-13-19

PRINTED: 12/07/2
FORM APPROV
OMB NO. 0938-0001

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION POC #2	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2018
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NAME OF PROVIDER OR SUPPLIER

THE WATERS OF SHELBYVILLE, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

**835 UNION STREET
SHELBYVILLE, TN. 37160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 657 SS=D	<p>A recertification survey was completed on 12/5/18 at The Waters of Shelbyville. Deficiencies were cited under 42 CFR PART 483, Requirements for Long Term Care Facilities.</p> <p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <ul style="list-style-type: none"> (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- <ul style="list-style-type: none"> (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of facility</p>	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

S. Allison RN

TITLE

12/28/18

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	<p>Continued From page 1</p> <p>documents, medical record review and interview, the facility failed to revise care plans for 2 Residents (#26 and #44) of 31 residents reviewed.</p> <p>The findings include:</p> <p>Review of an undated facility policy, Care Plan Review, revealed "...all residents receive a review of the Plan of Care by the Interdisciplinary Team at least quarterly..."</p> <p>Review of the facility's undated Daily Clinical Control Quality Improvement Meeting form revealed "...care plan updates as appropriate..."</p> <p>Medical record review revealed Resident #26 was admitted to the facility on 6/16/06 with diagnoses included Cerebral Palsy, Gastrostomy (G-tube), Dysphagia, Dry Mouth, and Flatulence.</p> <p>Medical record review of a Physician's Order dated 11/21/18 revealed "...Enteral Feed every day and night shift Nutren 2.0 [enteral formula] @ [at] 40 ml/hr [milliliters per hour] x [times] 25 hours turn on at 0000 [12 AM] turn off at 2200 [10 PM] (May use Isosource 1.5 [enteral formula] until Nutren 2.0 available) H2O [water] auto flush via [by] percutaneous endoscopic gastrostomy peg tube (g-tube)@ 30 ml/hr x 22 hours/day. Turn on @ 0000 Turn off @ 2200, start 11/21/2018 22:00."</p> <p>Medical record review of the Care Plan revealed "...[resident] is NPO [nothing by mouth] and is receiving tube feedings x 20 hours with auto H2O flush per pump. He has a 16 french g-tube with a 20 ml bulb. He is given Nutren 2.0 @ 50 ml/hr [hour] x 22 hours turn on at 0000 turn off at 2200</p>	F 657	<p>F 657 Care Plan Timing and Revision</p> <p>CFR(s): 483.21(b)(2)(i)-(iii)</p> <p><u>Corrective actions for areas affected:</u></p> <p>On 12/6/18 the MDS Coordinator Immediately reviewed physician orders and care plans were updated for resident's #26 for enteral feeding and #44 for Do Not Resuscitate code status.</p> <p>On 12/7/18 the DON educated the Interdisciplinary Team, (IDT - ADON, Clinical Nurse Manager, MDS, Social Services, Dietary) on the daily Clinical Meeting with emphasis on the review of MD Orders written in the last 24 hours and with emphasis on the responsibility of the MDS Coordinator and Clinical Nurse Leader to ensure care plans are updated in accordance with changes in MD Orders.</p> <p><u>Identification of other areas that could be affected by the deficient practice</u></p> <p>All residents could be affected by this deficient practice. On 12/7/18 the DON/ADON and MDS Coordinator conducted an audit of MD orders for residents receiving enteral feedings and resident code status and confirmed accuracy of care plans to ensure care plans reflected current MD orders. Care plans were updated as appropriate.</p> <p><u>Measures put in place to ensure the deficient practice does not reoccur:</u></p> <p>On 12/7/18 the DON educated the Interdisciplinary Team (IDT - ADON, Clinical Nurse Manager, MDS, Social Services, Dietary) on the daily Clinical Meeting with emphasis on the review of MD Orders and the responsibility of the MDS Coordinator and Clinical Nurse Leader to ensure care plans are revised as appropriate to reflect changes in MD Orders.</p>		1/15/19

S. Allison RN DON 12/28/18

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SHELBYVILLE, TN 37160**

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F 657	<p>Continued From page 2</p> <p>(May use Isosource 1.5 until Nutren 2.0 available) H2O auto flush via peg tube (G-tube) @ 30 ml/hr x 22 hours/day. Turn on @ 0000. Turn off @ 2200. He is monitored for residual and placement of g-tube every shift and PRN [as needed]..."</p> <p>Interview with Registered Nurse #1 on 12/5/18 at 5:52 PM at station 1 revealed the update of the resident "Care Plans are part of the SWAT (Skin And Weight Assessment Team) team and the different departments are delegated to put in a note or change the order." Further interview confirmed the facility failed to update the Care Plan to reflect a change.</p> <p>Medical record review revealed the facility admitted Resident #44 on 9/6/18 with diagnoses included Heart Failure, Vascular Dementia with Behavioral Disturbance and Encounter for Palliative Care.</p> <p>Medical record review of Resident #44's Tennessee Physician Orders for Scope of Treatment (POST) form dated 11/23/18 revealed "...Do Not Attempt Resuscitation [DNR/no cardiopulmonary resuscitation (CPR)], limited additional interventions no artificial nutrition by tube, no intubation..."</p> <p>Review of a Physician's Order dated 11/23/18 revealed "...DNR with limited interventions. Do not intubate. No mechanical life sustaining measures..."</p> <p>Review of the comprehensive care plan dated 11/5/16 and revised on 10/6/18 revealed "...Full Code/CPR, limited interventions, no artificial nutrition by tube, do not intubate..."</p>	F 657	<p><u>This corrective actions will be monitored by:</u></p> <p>Effective 12/21/18, The DON/ADON or designee will conduct a random review of 10% of physician orders to ensure care planning updates are completed as appropriate. Any identified concerns will be immediately corrected and addressed with re-education of staff or discipline as appropriate. Reviews will be conducted five times per week for twelve weeks then weekly for eight weeks or until 100% compliance achieved.</p> <p>The Director of Nursing or designee will forward results of audits to the Administrator for review. The Administrator will forward results to QAPI committee monthly for review to identify any patterns and recommendations. Any identified patterns will have an action plan written, to be followed by the Administrator or designee weekly until resolution.</p>	1/15/19

S. Allison Rawdon

12/28/18

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F 657	Continued From page 3 Interview with the Director of Nursing (DON) on 12/5/18 at 9:59 AM in her office revealed physician orders were reviewed daily and care plans were updated accordingly. Further interview with the DON revealed the Minimum Data Set (MDS) Coordinator was responsible for updating the care plans. The DON reviewed the physician order and care plan for Resident #44 and stated "Yep it's not updated."	F 657			
F 693 SS=D	Interview with the MDS Coordinator on 12/5/18 at 10:07 AM in her office confirmed physician orders are reviewed daily and care plans were updated according to the orders. Further interview with the MDS Coordinator confirmed Resident #44's care plan was not updated. She stated "It should have been updated when the orders were received." Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693			

S. Allison RN DON 12/28/18

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F 693	<p>Continued From page 4</p> <p>and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on facility policy review, medical record review, observation and interview, the facility failed to administer the rate of a tube feeding as ordered and failed to administer the tube feeding as ordered for 1 Resident (#26) of 5 residents receiving tube feeding.</p> <p>The findings include:</p> <p>Review of an undated facility policy, Enteral Tube Medication Administration revealed, "...Verify physician's orders...Right resident; Right medication; Right dose; Right route; Right time..."</p> <p>Medical record review revealed Resident #26 was admitted to the facility on 6/16/06 with diagnoses included Cerebral Palsy, Gastrostomy, Dysphagia, Dry Mouth, and Flatulence.</p> <p>Medical record review of a Physician's Order dated 11/21/18 revealed "...Enteral Feed every day and night shift Nutren 2.0 [enteral formula] @ [at] 40 ml/hr [milliliters per hour] x [times] 25 hours turn on at 0000 [12 AM] turn off at 2200 [10 PM] (May use Isosource 1.5 [enteral formula] until Nutren-2.0 available) H2O [water] auto-flush via percutaneous endoscopic gastrostomy (peg tube) @ 30 ml/hr x 22 hours/day Turn on @ 0000 Turn off @ 2200, start 11/21/2018 22:00..."</p> <p>Observation on 12/3/18 at 9:37 AM, and 3:47 PM revealed Resident #26 was administered Nutren 2.0 tube feeding at 50 ml/hr instead of 40 ml/hr as</p>	F 693	<p>F 693 Tube Feeding Mgmt/Restore Eating Skills</p> <p>CFR(s): 483.25(g)(4)(5)</p> <p><u>Corrective actions for areas affected:</u></p> <p>On 12/6/18 the charge nurse reviewed the physician's orders for Resident # 26 regarding the infusion flow rate for the enteral feeding pump and the flow rate was immediately adjusted to 40 milliliters per hour in accordance with the MD order.</p> <p>Licensed nurses were educated by the DON and Unit Manager on 12/7/18 regarding the transcription and implementation of MD orders for tube feeding infusion rates. Emphasis was communicated regarding immediate changing of infusion flow rates as prescribed by MD and ongoing monitoring of the infusion to ensure MD orders followed regarding infusion flow rates.</p> <p><u>Identification of other residents having the potential to be affected by the same deficient practice and corrective actions taken</u></p> <p>All residents receiving enteral feedings per pump infusion are at potential risk. On 12/7/18 Clinical Nurse Supervisor reviewed the MD orders for all residents receiving enteral feedings to ensure current orders for tube feeding infusion rates match current flow rates administered. Any changes will be corrected immediately with education or counseling completed as appropriate.</p>		11/5/19

S. Allison RN DON 12/28/18

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F 693	Continued From page 5 ordered. Observation on 12/3/18 at 12:08 PM, 3:24 PM and on 12/4/18 at 7:46 AM revealed Resident #26 was not receiving the tube feeding as ordered from 12 AM to 10 PM. Observation and interview with Licensed Practical Nurse (LPN) #4 on 12/4/18 at 4:53 PM on the station 1 hall revealed Resident #26 was receiving the tube feeding at 50 ml/hr. Further interview when asked if the enteral order was changed?, LPN #4 stated "...if it had been changed they haven't changed it in the medical record..." Further interview confirmed the enteral feeding order had been changed to 40 ml/hr on 11/21/18. Further interview confirmed "...sometimes he's sitting out of his room and he would be off the tube feeding..."	F 693	<u>Measures put in place to ensure the deficient practice does not reoccur:</u> Effective 12/20/18, when changes are made in the IDT Skin and Weight Meeting (SWAT), any recommendations or changes in resident's care will be documented and communicated to the floor staff via a SWAT Communication Form. The DON or her designee will provide a verbal report and copy of the SWAT Communication Form to the licensed nurse. Both parties will sign off on the form upon information exchange. <u>This corrective action will be monitored by:</u> The SWAT Communication Forms will be maintained in a notebook and reviewed weekly on the day after the IDT skin and weight meeting (SWAT) and the DON/ADON/ Designee will then go to the resident's rooms and charts to verify infusion rate of enteral feeding in accordance with physician order. The DON/ADON/Designee will then provide a third signature to the SWAT Communication Form. All findings will be presented to QAPI meeting each month until compliance is 100%. The Director of Nursing or designee will forward results of audits to the Administrator for review. The Administrator will forward results to QAPI committee monthly for review to identify any patterns and recommendations. Any identified patterns will have action plan written, to be followed by the Administrator or designee weekly until compliance reached.		1/15/19
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758			
	Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs				

Ballison RN 12/28/18

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F 758	<p>Continued From page 6</p> <p>unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, the facility failed to provide monitoring related to performing Abnormal Involuntary Movement Scale (AIMS) assessments in a timely manner for 1 Resident (#4) of 27 residents receiving Anti-Psychotic medications.</p>	F 758	<p>F 758 Free from Unnecessary Psychotropic Drugs</p> <p>CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p><u>Corrective actions for areas affected:</u></p> <p>On 12/5/18 the DON completed an AIMS Assessment for Resident #4.</p> <p><u>Identification of other residents having the potential to be affected by the same deficient practice and corrective actions taken</u></p> <p>All residents who are receiving psychotropic medications have the potential to be affected.</p> <p>On 12/10/18 the IDT Team reviewed residents receiving psychotropic medications to ensure AIMS assessments were completed quarterly. AIMS Assessments were updated as indicated.</p> <p><u>Measures put in place to ensure the deficient practice does not reoccur:</u></p> <p>On 12/10/18 the licensed nurses were in-serviced by the DON/ADON on the frequency requirements (admission, quarterly, and annually) for completion of AIMS Assessments</p> <p>Newly employed licensed nurses will receive education by the DON/ADON on the frequency requirements (admission, quarterly and annually) for completion of AIMS Assessments during the orientation/clinical onboarding process.</p> <p>The licensed nursing staff will be educated on forwarding the completed "Clinical Assessments Check-off" form to DON/ADON to confirm completion of AIMS assessments. Any concerns identified will be immediately addressed including staff education and counseling.</p>	1/15/19	

S. Allison RN DON 12/28/18

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F 758	Continued From page 7 The findings include: Medical record review revealed Resident #4 was admitted to the facility on 3/20/17 with diagnoses including Unspecified Dementia with Behavioral Disturbance. Medical record review of a Physician's Order dated 5/30/17 revealed "...Seroquel 25 milligrams (mg) by mouth twice a day..." Medical record review revealed the last AIMS performed for Resident #4 was completed on 10/24/17. Interview with the Director of Nursing on 12/5/18 at 3:48 PM in her office confirmed Resident #4 did not have an AIMS completed since October 2017. She stated, "I know they are to be done quarterly by the nurses, we have a breakdown."	F 758	<u>This corrective action will be monitored by:</u> Effective 1/7/18 the DON/ADON will conduct a monthly audit of AIMS Assessments completed per schedule. A report will be reviewed from the electronic record to ensure AIMS Assessments are completed in accordance with the assessment schedule. Any concerns identified will be immediately corrected with education and counseling of staff as appropriate. Audits will be completed monthly for a period of 6 months and results forwarded to the Administrator for review and QAPI Committee for review monthly and re-evaluated after 6 months for completion and/or continuation. Effective 12/12/18 the DON/ADON/designee will review the medical records of new admissions who are prescribed psychotropic medications during Clinical Meetings to ensure AIMS Assessments are completed in accordance with the assessment schedule. Any concerns identified will be immediately corrected with education and counseling of staff as appropriate. The Director of Nursing or designee will forward results of audits to the Administrator for review. The Administrator will forward results to QAPI committee monthly for review to identify any patterns and recommendations. Any identified patterns will have action plan written, to be followed by the Administrator or designee weekly until resolution.		11/5/19

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E 000	Initial Comments An Emergency Preparedness survey was completed on 12/5/18 at The Waters of Shelbyville. No deficiencies were cited under FED-E-1.00.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

S. Allison B. Tamm 12/28/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.